

U.S. Department of Health and Human Services National Advisory Council on Migrant Health (NACMH)

**October 22-23, 2014
Pittsburgh, PA**

Council Members in Attendance

Frances Canales
Edelmiro Garcia
Gwendolyn Gould
Jill Kilanowski
Martha Lopez
Rosa Martin
Victoria Montoya
Jesus Tijerina
Joan Tronson
Wenceslao Vasquez

Federal Staff

Office of National Assistance and Special Populations, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services

Jacqueline Rodrigue, Designated Federal Official, NACMH
Gladys Cate, Support Staff, NACMH

WEDNESDAY, OCTOBER 22, 2014

CALL TO ORDER

Jill Kilanowski, PhD, RN, APRN, CPNP, FAAN (Chair)

NACMH Chair Jill Kilanowski called the meeting to order at 8:06 a.m.

NACMH Vice Chair Edelmiro Garcia moved to approve the agenda with no changes. The motion was seconded by Victoria Montoya and carried by unanimous voice vote.

Council members introduced themselves for the record.

Martha Lopez moved to approve the minutes of the previous meeting (April 8-9, 2014). The motion was seconded by Joan Tronson and carried by unanimous voice vote.

BUREAU OF PRIMARY HEALTH CARE (BPHC) UPDATE

CDR Jacqueline Rodrigue, MSW, Designated Federal Official for the NACMH

Presentation highlights:

- BPHC's mission is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.
- BPHC accomplishments by priority area
 1. Increase access to primary health care services for underserved populations
 - Health center grantees in all 50 states and more than 1,300 sites, with 651 new access points established since 2009
 - 27 percent increase in patients served since 2008
 - \$295 million awarded for Expanded Service grants
 - Helped six million people obtain health insurance
 - Health centers served nearly 23 million patients in 2013, many of whom were low-income, minority, and uninsured.
 2. Modernize the primary health care safety net infrastructure and delivery system
 - Nearly 2,300 service delivery sites have been modernized.
 - 96 percent of health centers have Electronic Health Records (EHRs).
 - 54 percent of health centers are recognized as Patient Centered Medical Homes (PCMHs).
 3. Improve health outcomes for patients
 - Clinical outcomes routinely surpass national averages in key areas (prenatal measures, chronic disease management, and preventive services).
 - 2009 Health Center Patient Survey found no racial/ethnic disparities in access to primary care and patient satisfaction, cancer screenings, hypertension, and diabetes.
 4. Promote a performance-driven and innovative internal organizational culture
 - Seven years of health center clinical performance reporting
 - Health center performance data are updated and available to the public
 - Moving toward a rapid cycle, quality improvement organization with internal and external accountability.
- Program and policy updates
 - Recent and anticipated health center program policies
 - Final Policy Information Notices (PINs): Sliding Fee Discount Program; Governance; Revised Total Budget
 - Updated Program Assistance Letter (PAL): Health Center Program Requirements Oversight
 - Program requirements manual.

- Fiscal Year 2014 (FY14) health center awards
 - \$150 million for New Access Points (236 grants)
 - \$58 million for ACA Outreach and Enrollment (1,157 one-time grants)
 - \$54.6 million for Mental Health Service Expansion/Behavioral Health Integration (221 grants)
 - \$35.7 million for PCMH Capital Awards (147 grants)
 - \$110 million in Base Adjustments
 - \$295 million for Expanded Services to 1,195 health centers
 - \$9.9 million to enhance HIV services in health centers.
- President's Budget for FY15
 - \$4.6 billion (\$3.6 billion from the ACA Community Health Center Fund)
 - \$100 million to fund 150 new health center sites
 - \$860 million for quality improvement and capital development
 - Continuation of mandatory funding through FY18 (\$2.7 billion annually).
- Affordable Care Act (ACA)
 - Health centers supported over 16,000 trained outreach and enrollment assistance workers and assisted more than six million people to become insured
 - HRSA is providing continuing support for health center outreach and enrollment.
- Migrant Health Program Update
 - Migrant health centers (MHCs) served nearly 790,226 patients in 2013 through 169 grantees with more than 1,880 service sites.
 - Since 2008, MHCs have served nearly 18,000 new patients, added 418 new sites, and hired 8,463 new employees.
 - MHCs receive high scores on key national indicators (EHRs, PCMH recognition, clinical performance).
 - MSAW demographics
 - 73 percent male; one-third over age 35; 73 percent Spanish-speaking.
 - Agricultural workers' challenges
 - Poverty, crowded households, limited education, no health insurance.
 - Call Center Initiative
 - Collaborative effort between the National Center for Farmworker Health (NCFH) and the National Alliance for Hispanic Health (NAHH)
 - Goals: 1) Increase knowledge and awareness of ACA eligibility among potential Hispanic enrollees; 2) Increase access to health care and other related services.
 - Training and Technical Assistance (T/TA) Resources
 - Provided through National Cooperative Agreements (NCAs) with Farmworker Justice, Health Outreach Partners, MHP Salud, Migrant Clinicians Network, National Association of Community Health Centers (NACHC), and NCFH.

Discussion

- Do the prenatal care data provided in the slides include teen pregnancies?

- Data are not broken down by age.
- Does the Uniform Data System (UDS) collect data on dental and vision screenings?
 - CDR Rodrigue can provide that information.
- It would be helpful to have data on the cultural competency training provided by health centers to identify best practices models.
 - The UDS does not collect that information.
- Are migratory and seasonal agricultural workers (MSAWs) able to access the ACA?
 - H2-A workers are eligible for coverage, but many have elected not to purchase it due to the short duration of their stay in the U.S.
- What was the basis of comparison for measuring the impact of PCMH recognition?
 - The PCMH-recognized health centers were compared to the national average for each indicator.
- Do the EHR systems at different health centers talk to each other?
 - HRSA's EHR team has worked closely with health centers to address that issue.
- Do health centers conduct weight screenings on children?
 - The UDS does collect this information.
- Do the funds that were listed include salary increases for health center staff?
 - Salary decisions are made by the advisory board for each health center.
- What types of mental health services are provided at health centers? Are these services available for both adults and younger populations?
 - Health centers provide behavioral health services for younger populations as well as adults. NCAs have conducted training on behavioral health screenings at school-based health centers and have helped to make referrals for mental health services.
- Please provide more information on the grantees that provide training.
 - The six NCAs provide training and technical assistance to help MHCs meet program requirements and improve performance outcomes. Some focus on governance; others have focused on the sliding fee discount; others have focused on improving clinical outcomes. The NCAs offer a range of training and technical assistance, including webinars and toolkits to help health centers integrate best practices and promising approaches; develop policy briefs for health center staff; and provide training to improve clinical outcomes.
- Why did the number of patients served decline between 2012 and 2013?
 - Two health centers had reporting errors, which have been addressed.
- The increase in the number of sites (28 percent) was greater than the increase in the number of patients (2 percent). Was this a factor in the improved quality of care?
 - The additional sites allowed health centers to improve quality of care, and they have continued to make strides in their clinical outcomes.

Council members identified the following issues to incorporate in recommendations to the Secretary:

- Isolate data on teen pregnancies from all prenatal care
- Provide data on oral health and vision screening
- Provide data on weight screening of children

- Accountability for cultural competency training, especially in light of changing demographics
- Expand behavioral health services for children and adults
- Impact of staff turnover on cultural competency training
- Impact of changes in migration patterns and shift to seasonal work
- Information on EHR implementation and ability of health centers to share data
- ACA outreach and enrollment assistance for H-2A workers
- MSAWs in isolated locations may not have access to providers even if they have coverage
- Impact of MSAWs shifting to other types of work that offer health insurance.

WELCOME TO PITTSBURGH

Cheri Rinehart, RN, NHA, President and CEO, Pennsylvania Association of Community Health Centers (PACHC)

Presentation highlights:

- PACHC represents federally qualified health centers (FQHCs), FQHC look-alikes, rural health clinics, and other like-mission primary care providers. Its members include two migrant health grantees (Keystone Health and La Comunidad Hispana).
- Pennsylvania MSAWs
 - The statewide MSAWs population is 28,989; two-thirds are MSAWs; there are 92 H2-A camps.
 - The season is July 5 through mid-November for tree fruits and mid-August to mid-October for tomatoes. MSAWs are also employed in planting, harvesting, and pruning from April through October.
- MSAW population trends
 - Evolving diversity (Mexicans, Central Americans, Haitians, Jamaicans, Somalis, Sudanese, Iraqis, Ethiopians, Russians, and Ukrainians)
 - Decline in the number of MSAWs since the Arizona decision
 - Decline in the number of farms
 - Fewer MSAWs picking the entire way up and down the migrant stream
 - Crew chief system is still prevalent
 - More MSAWs living in small apartments
 - Limited literacy, especially for Haitians and Guatemalans.
- Positive trends
 - Education and immunization rates for migrant children have improved.
 - Dental care has improved and dental caries is decreasing with increased use of fluoride varnish. PACHC is working with the DentaQuest Foundation.
- MSAW healthcare trends
 - Pesticide spraying occurs before MSAWs arrive, which limits exposure

- Musculoskeletal injuries
- Chronic diseases (diabetes, hypertension)
- Skin rashes (poison ivy, poison sumac, poison oak)
- Sexually transmitted diseases (STDs) and HIV, especially in younger workers
- Acute depression, especially for those away from home for the first time
- Malnutrition
- Prostitution and alcohol use
- Drug use is generally not an issue.
- Health insurance trends
 - Many mushroom pickers now have health insurance
 - Eligible MSAWs are reluctant to sign up for health insurance
 - MHC grants do not cover diagnostic or specialty care.
- “Wish list” of Pennsylvania MHCs
 - Stable, national formulary for use throughout the migrant stream
 - Basic, effective medication (i.e., not samples)
 - Funding for mobile units
 - Better utilization of the national CHC network.
- PACHC developed a new definition for the FQHC acronym
 - Fees based on ability to pay
 - Quality primary healthcare, open to all
 - Highly competent healthcare professional team
 - Community control.
- PACHC developed a new FQHC logo that emphasizes community, quality, and the concept of a medical home. The logo has been adopted by the NACHC.

Discussion

- The younger generation of MSAWs is very motivated toward education. Literacy is primarily an issue among older MSAWs.
- Racial profiling and language barriers contribute to depression.
- What are the factors behind the uptake of insurance among mushroom pickers?
 - Mushrooms are harvested year-round. Health centers employ outreach and enrollment workers and provide assistance to complete enrollment forms.
- The new FQHC acronym and logo are very appealing.
 - PACHC wants health centers to be the provider of choice, the employer of choice, and the partner of choice. The new acronym has been very helpful in overcoming misperceptions and creating awareness.
- Many people think of CHCs as healthcare for the poor. One grantee is naming its centers to make them attractive to patients who have insurance.
- Nurse practitioners have an established formulary that provides consistency in care.
- Is the fluoride varnish a part of routine care for children?
 - That is a goal; Pennsylvania health centers are currently conducting fluoride varnish events.

- The increasing number of MSAWs who are refugees will impact the needs for cultural competency. Will they displace current MSAWs?
 - Most of the refugees are located in northwest Pennsylvania.
- Access to specialty care is important for MSAWs. Does Pennsylvania use the voucher program?
 - That program was not mentioned by the MHCs.
- What variables were measured to determine that education for MSAW children has improved?
 - That was a general consensus statement from MHC representatives; it was not supported with data.
- The speaker mentioned that MHCs do not always know when families leave the area. The Migrant Education Program has a records transfer program that goes with the child, and they often partner with MHCs.
- MSAWs and the American public rely on farms. We need to find ways to retain the family farms that employ many of the agricultural workers.
 - There are growing numbers of farm-to-table restaurants, enrollment in Pennsylvania State University’s agricultural degree program is increasing, and there are new champions for small farms. But it is difficult to turn down a lucrative offer for farmland.

Council members identified the following issues to incorporate in recommendations to the Secretary:

- Continued support for literacy and health literacy
- Access to specialty care.

CHALLENGES FACED BY THE AGING MIGRATORY AND SEASONAL AGRICULTURAL WORKFORCE

M. Margaret Weigel, PhD, Professor of Public Health Sciences & Director, MPH Program, College of Health Sciences, University of Texas at El Paso, TX (via teleconference)

Presentation highlights:

- There is a lack of consensus on who constitutes an “aging” or “older” worker. U.S. laws and public policies differ (e.g., age discrimination protection begins at 40, U.S. Bureau of Labor Statistics uses 55).
- The MSAW workforce is aging. The average age is 38, and approximately one-third are 44 or older. In the Southwest region, 57 percent of MSAW are over the age of 40.

Factors include:

- Declining numbers of Mexican nationals seeking agricultural work in the U.S.
- Reluctance of U.S. citizens to do agricultural work
- Increasing consumer demand for fresh produce
- Poor access to retirement, disability, and other benefits for MSAWs
- Many aging immigrant MSAWs reluctant to return to their home country due to violence and extortion.

- Aging affects health conditions and outcomes, including the likelihood of on-the-job injury.
 - Increased risk for musculoskeletal injuries
 - Prolonged recovery time after surgery
 - Skin aging (increased absorption of chemical and biological agents; more skin injuries; decreased skin wound healing; skin cancers)
 - Changes in metabolism (including drugs and environmental agents)
 - Thermoregulation (heat and cold stress, heat stroke)
 - Immune status
 - Sleep health.
- Indicators used to study the health challenges of MSAWs over age 40 in the El Paso area
 - Work-related musculoskeletal injuries (especially strain, strain injuries, and fractures)
 - Clinical indicators of pain, disability, and functionality
 - Health-related quality of life (measured by the SF-36 functional health survey)
 - Chronic conditions.
- Key findings
 - 81 percent reported at least one persistent musculoskeletal injury (PMI).
 - None of the injured workers received physical therapy or occupational therapy.
 - 12 percent had scores suggesting severe osteoarthritis requiring possible knee replacement surgery, yet all returned to work.
 - As the number of current work-related PMIs increased, balance, strength, and walking scores decreased significantly.
 - As musculoskeletal injuries increased, quality of life decreased significantly.
- Top five chronic conditions reported by aging MSAWs
 - Eye/vision problems
 - Dental problems (can impact nutrition)
 - Gastrointestinal
 - Cardiovascular
 - Emotional/psychological.
- Conclusions and recommendations
 - There is an urgent need for focused research on aging MSAWs to better understand issues related to work environment and safety; health and health care; food security/nutrition; and quality of life/well-being.
 - Many of the injuries and health challenges of aging MSAWs that have been identified to date are potentially preventable and/or amenable to intervention.
 - There is an urgent need for culturally appropriate, evidence-based integrated interventions.
 - Current policy, programs, and practices should be reviewed.

Discussion

- Does the information on average MSAW age include all MSAWs? Are data available on women?
 - The information represents all MSAWs. The study included very few female MSAWs in their upper 50s or above, but quite a few in their 40s.
- Please elaborate on the recommendation for culturally appropriate interventions.
 - Many health care providers in the El Paso area speak Spanish, but they do not understand the challenges and needs of MSAWs. Language and cultural barriers are common in other parts of the country.
- Please clarify what is meant by the term “ethnospecific illness.”
 - Those were manifestations of psychosocial problems that conventional medicine does not recognize, or alternative explanatory systems for physical symptoms.
- How prevalent are alcohol or drug consumption?
 - Older workers reported problems with alcohol. They also reported feeling depressed because they were unable to work as much as they used to.
- What are the consequences of pesticides on older workers?
 - Older workers may metabolize pesticides faster, but no research has been done.
- How did the research team collect data for the study?
 - A bi-cultural team collected data at the MSAW center during the regular season (141 workers in the first sample, 177 workers in the second sample).
- Did participants in the study comment on access to health care?
 - Access to care is a problem in the El Paso area. MSAWs can no longer go across the border to access care in Mexico. Two community-based organizations receive migrant health funds. However, clinic hours are established for an urban population and are not conducive to MSAWs, and one of the centers charges high fees and has a long waiting list.

Council members identified the following issues to incorporate in recommendations to the Secretary:

- Need for differentiated data
- Vision/dental/mental health/pesticides
- Entities that receive migrant health funds need training to understand the needs of this population.

ROLE OF COMMUNITY HEALTH WORKERS (CHWs) IN MENTAL AND BEHAVIORAL HEALTH INTEGRATION

Gayle Lawn-Day, CEO, MHP Salud

Presentation highlights:

- Overview of CHWs/Promotoras de salud
 - CHWs serve populations that are difficult to reach.

- CHWs provide health education that is culturally, linguistically, and literacy-level appropriate because they come from the community they serve.
- CHW work is done through door-to-door visits, group education, community meetings, creating referral networks, and subcontracts for provider capacity.
- Why to use CHWs for mental and behavioral health integration
 - Need for services (Hispanic American youth are at significantly higher risk for poor mental health)
 - Limited availability of culturally and linguistically appropriate services
 - Limited access to services (Hispanics are the least likely to have health insurance)
 - Utilization of services (Hispanics are more likely to visit primary care providers than mental health providers).
- Latino MSAWs report high levels of depression rates across multiple studies. Rates fluctuate based on several factors (e.g., separation from family, literacy rate).
- There is a high interaction between mental health and physical health issues such as sleep disorders, musculoskeletal pain, and chronic conditions.
- Addressing Latino adolescents' mental health
 - Depression is reported by 40 percent of Latina adolescents, compared to 20 percent in other ethnic groups.
 - CHWs offer a holistic approach because they know the home environment and can work with parents and schools.
 - CHWs gather information that can increase program effectiveness.
 - CHWs provide follow-up and peer support that can reduce re-hospitalization.
- Mental health and chronic disease
 - The best tools emphasize the integration of multiple approaches
 - Need culturally appropriate terms and understanding, peer education, and promotoras
 - Promotoras can increase understanding of mental health and decrease the stigma associated with it; they can also address gender differences effectively.
- MHP Salud's experience in mental health programs
 - One-third of referrals made by promotoras in 2013 were for mental health.
 - Salud para Todos (1999-2006)
 - Mental health and substance abuse program for MSAWs in Maine and North Carolina
 - Ninety-five percent of CHW referrals resulted in care
 - Identified factors that prevented MSAWs from keeping appointments.
 - Nuevas Avenida (2006-2009)
 - CHWs worked with a medically underserved population in Texas.
 - Outcomes: 1) Increased ability to access behavioral health services; 2) increased ability to identify symptoms of depression, stress, and anxiety.
 - Futuros Saludables (2009-2012)

- One full-time CHW completed 1,800 individual health encounters that resulted in more than 1,100 referrals and 550 unduplicated services over three years.
 - De Hombre a Hombre (2012)
 - Door-to-door education provided by CHWs increased the extent to which MSAWs felt they understood and could prevent domestic violence.
 - Outcome surpassed expectations of the Office on Violence Against Women (OVW) by 279 percent.
- Evaluation is essential
 - Good evaluation can be done with inexpensive technology (e.g., smartphones, open source software); simple training that involves clinicians, providers, and CHWs; and commitment and understanding.
 - Good evaluation can produce cost savings, tailor community programs to produce real outcomes, and target effective practices.
 - Barriers such as difficulty in quantification, definition and measurement issues, and multicollinearity can be addressed.
- NACMH can build the case for CHWs as a component of behavioral and mental health care and can emphasize the need for:
 - Clear performance data
 - Outcome measures
 - Return on investment
 - Foregone costs (society, individual, institution).

Discussion

- How does MHP measure consistency and sustainability across sites?
 - Promotoras have a scope of work, but each state has its own requirements. Programs are not uniform, but there is external reliability and curricula are reviewed by a wide variety of experts. It is important to have an understanding of the parameters for flexibility to adapt programs.
 - CHWs need liability insurance.
- What type of education and training do CHWs have?
 - In the past, most CHWs had a high school education or less, and many did not speak English. Standards are now higher, and certification tests are in English.
- How can we promote this model to organizations that say they can't afford it?
 - Focus on return on investment and foregone costs. Start with a small program, with clear goals and measurement. CHWs need to be part of the team so that the information they gather can inform clinicians.

PUBLIC HEARINGS

A group of MSAWs working in Pennsylvania provided testimonies about their experiences related to health and health care. Key issues are summarized below.

- Experiences accessing health care

- The health center, specialist, and hospital did not have Spanish-speaking receptionists or providers.
- Exams seemed superficial, and providers did not seem to understand their concerns.
- MSAWs wait several hours, while other patients are seen first.
- MSAWs have to wait for several weeks for an appointment, unless it is scheduled through an outreach worker.
- A doctor tore up a prescription for a MSAW's child when he learned she did not have insurance, without asking if she could afford the medicine.
- MSAWs do not file complaints because they are afraid of repercussions.
- Other health issues
 - Drugs and alcohol: The female MSAWs stated that drug and alcohol use was not common among the men in their group.
 - Mental health: The female MSAWs were related and reported that they have a strong system of emotional support.
 - Domestic violence: The female MSAWs were aware of some stories, but women are reluctant to leave their husbands. Women have to be willing to speak up and must be able to trust that it will be confidential.
 - Teenage pregnancy: The female MSAWs said this does not occur very often in their group.
 - Health education: The MSAWs had seen posters in Spanish at the health center.
 - Affordable Care Act: The MSAWs said they did not receive information about the ACA at the health center.
- Work-related issues
 - Safety training is provided at the beginning of the season through a video on safety procedures and pesticide exposure.
 - The female MSAWs had not heard inappropriate language or experienced behaviors that made them uncomfortable. They noted that they work primarily among women.
 - This group of MSAWs does not migrate. They do other types of work during the off-season (e.g., grinding grapes for wine).
 - One work site just got bathrooms this year.
- Recommendations
 - Doctors and nurses who care for migrant patients
 - More thorough examinations
 - Equal treatment for all patients
 - More options for those who do not have insurance
 - Access to specialists at a reasonable price.

WRAP UP

Council members discussed the testimony session, including the list of questions and the information that the MSAWs provided. There was general consensus that the list of questions should be revised.

Dr. Kilanowski called for a motion to adjourn. The motion was made by Ms. Canales, seconded by Ms. Montoya, and carried by unanimous voice vote. The meeting was adjourned at 5:00 p.m.

THURSDAY, OCTOBER 23, 2014

Dr. Kilanowski called the meeting to order at 8:02 a.m.

RECAP FROM DAY ONE

Edelmiro Garcia, Vice Chair

Mr. Garcia summarized the key issues that emerged during the previous day.

Dr. Kilanowski proposed two additional items to discuss:

- Identify issues for recommendations from two presentations (aging MSAWs; CHWs and behavioral health)
- Review the list of questions to be used for MSAW testimonies.

Mr. Tijerina moved to add those items to the agenda. The motion was seconded by Mr. Garcia and carried by unanimous voice vote.

PATIENT NAVIGATION SERVICES AND MARKETPLACE FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

Alexis Guild, MPP, Migrant Health Policy Analyst, Farmworker Justice

Presentation highlights:

- Overview of the open enrollment period for health insurance coverage:
 - Over eight million people enrolled in the health insurance marketplace
 - Providing ethnicity was optional. Self-reported data were as follows: 62.9 percent White, 16.7 percent African-American, 10.7 percent Latino, and 7.9 percent Asian
 - Eighty-five percent of enrollees received tax credits to lower the cost of health insurance.
- Open enrollment 2015 (November 15, 2014-February 15, 2015):
 - Focus on re-enrollment of currently insured and outreach to the remaining uninsured.
 - Large employers (more than 100 employees) will be required to offer health insurance to full-time employees starting January 1, 2015. This may provide coverage to some MSAWs.
 - Consumers' authorization of an assister is now valid for 1 year instead of 14 days.
 - More bilingual call center representatives will be hired and training will be improved.
 - Navigator grants have been expanded, including grantees in MSAW service areas.

- Special Enrollment Periods:
 - Individuals who have a “triggering event” have 60 days to enroll in health insurance. Gaining lawful immigration status is a triggering event.
 - The majority of H-2A workers must enroll using a Special Enrollment Period because they arrive after the end of open enrollment.
- Open enrollment vs. Special Enrollment Periods:
 - **Similarities**
 - Can apply with the help of navigators and in-person assisters.
 - Marketplace application and availability of tax credits/cost-sharing reductions.
 - **Differences**
 - Start date of coverage depends on the triggering event
 - Can only qualify for a Special Enrollment Period by phone or online. This has been challenging for H-2A workers. MSAWs are most successful in enrolling when they have in-person assistance.
- Ongoing challenges to MSAW enrollment:
 - Lack of resources for patient navigation, especially between open enrollment periods and in rural areas
 - Workers lack knowledge of the ACA and health insurance
 - Migration to new coverage areas (within a state and between states)
 - Misinformation about eligibility for H-2A workers
 - Language access and cultural competency, especially among marketplace call center employees
 - Online identity verification requires a U.S. credit history
 - Immigration status verification
 - Incorrect eligibility determinations (lawfully present workers who are below 100 percent of the federal poverty level)
 - Fewer options to enroll in between open enrollment periods.
- Lessons learned in the first open enrollment period:
 - Navigators and in-person assisters are essential to successful MSAW enrollment.
 - Most MSAWs were interested in purchasing health insurance once they learned about the importance of coverage and their options in the marketplace.
 - There is ongoing confusion about MSAW eligibility (especially H-2A workers) among outreach and enrollment staff and call center staff.
 - Many navigators and in-person assisters developed their own workarounds and best practices to facilitate MSAW enrollment.
- Farmworker Justice recommendations:
 - BPHC staff who work with migrant health centers and have knowledge of special populations can support CMS to ensure that call center staff understand the needs of MSAWs and provide culturally and linguistically appropriate enrollment assistance.

- At both the PCA and the health center level, special populations staff should work closely with outreach and enrollment staff to develop strategies and best practices for MSAW enrollment.
- CMS and BPHC should provide additional guidance and information to health centers on Special Enrollment Periods.
- CMS and BPHC should provide guidance and information to navigators and in-person assisters about the multi-state plan.
- CMS should modify the paper application to allow H-2A workers and others gaining lawful immigration status to claim Special Enrollment Period eligibility.
- Health centers with large concentrations of H-2A workers should have the opportunity to apply for short-term funding to conduct additional outreach and enrollment during Special Enrollment Periods.
- H-2A workers who were not able to enroll in health insurance during 2014 should be allowed to apply for a hardship exemption from the individual mandate.

Discussion

- A migrant who enrolled in Texas could not use her coverage in Minnesota, although she had to pay the premiums. She was not planning to re-enroll.
 - That is a major issue for MSAWs.
- Is coverage for H-2A workers pro-rated?
 - H-2A workers' pay the same monthly premium. They must disenroll before they leave, which is a straightforward process.
- Could a migrant disenroll and re-enroll in the state where they work?
 - That can be challenging, especially for migrants who move several times. Every state has its own residency requirements. Moving to a new coverage area would trigger a Special Enrollment Period.
 - A multi-state plan that would be ideal for MSAWs is not well advertised and is not available in every marketplace.
 - There is a need for better coordination between HRSA and CMS to disseminate information about the options available in the marketplace, including the multi-state plan.
- MSAWs working in the same county are often moved from one contractor to another. Who is responsible for their coverage?
 - It is unclear whether the contractor or the employer would be responsible for providing coverage. The employer mandate includes a six-month exemption for seasonal workers, and a bill is pending in Congress to expand the exemption beyond six months. It is unclear how many growers will fall into that category. Farmworker Justice will follow this issue closely.
- Has Farmworker Justice provided its recommendations to the federal government?
 - Farmworker Justice sent a memo to HRSA and submitted recommendations to CMS. It is important for the government to hear from as many voices as possible.

- What was the feedback regarding the recommendations?
 - HRSA's feedback was positive. CMS was sympathetic to the issues, but they emphasized that changes would take time.
- How knowledgeable are health centers about the grants for navigators?
 - BPHC will continue to support outreach and enrollment and recently formed a collaborative to establish a call center specifically for H-2A workers.
- Has Farmworker Justice conducted outreach to other ethnic and language groups, given the changing demographics of the MSAW population?
 - Most MSAWs are still Latino, and most H-2A workers are from Mexico. There is more work to do to reach non-Latino MSAWs. Farmworker Justice would like to provide materials in Creole, but they do not have the resources.
- Do Haitian and Jamaican MSAWs have refugee status?
 - They are here legally. The speaker did not know the immigration status of the Haitian workers. Jamaicans MSAWs have H-2A visas.

Council members identified the following issues to incorporate in recommendations to the Secretary:

- Portability of coverage
- Coordination between HRSA and CMS regarding ACA implementation
- More training for outreach and enrollment staff.

POLICY UPDATE

Joseph Gallegos, MBA, Senior Vice President for Western Operations, National Association of Community Health Centers (NACHC)

Key presentation points:

- Environment in Washington
 - Political polarization, with heightened scrutiny of federal programs, budget caps, and uncertainty of future funding.
 - Bipartisan support for the health center program and mission.
- Health centers in a post-ACA world
 - Access to primary care is vital for cost savings and improved outcomes
 - Unmet needs for services remains enormous (62 million without primary care)
 - Increased demand for primary care among newly insured and uninsured
 - Federal support through Section 330 grants and Medicaid payments is crucial to the health center model of care.
- FY 2015 funding for health centers
 - New funding is essential for base grant adjustments, expanded capacity, service expansion, and new access points.
 - Since the ACA, funding for health centers comes through two streams

- Discretionary: Annual budget, determined by Congress. Only funding source for CHCs prior to the ACA. Currently \$1.5 billion.
 - Mandatory: A special five-year Trust Fund created in the ACA to boost health center capacity. Set to expire in FY2016. Currently \$2.2 billion.
- FY 2015 budget
 - NACHC requested \$1.5 billion in discretionary funding and \$3.6 billion in mandatory funding, for a total of \$5.1 billion.
 - The President's Budget requested \$1 billion in discretionary funding and \$3.6 billion in mandatory funding, for a total of \$4.6 billion.
 - The Senate subcommittee passed a total allocation of \$5.1 billion.
 - The budget process has stalled until after the elections, and possibly into 2015.
- Health centers funding cliff
 - Mandatory funding expires at the end of FY15. Without Congressional action, health center grants will be cut by up to 70 percent.
 - The National Health Service Corps (NHSC) and Teaching Health Centers (THCs) are also affected.
- NACHC's plan
 - Continue discretionary funding at \$1.5 billion
 - Extend the mandatory funding for five years, with modest growth
 - Grow from current 22 million patients to 35 million
 - Continue funding for NHSC and THCs.
- NACHC priorities for Fall 2014
 - Educate communities about the funding cliff.
 - Increase outreach and awareness of the potential impact of the funding cliff.
- Medicare/Medicaid/Children's Health Insurance Program (CHIP)
 - The Medicare Sustainable Growth Rate bill passed in March included an eight-state demonstration on "Certified Community Behavioral Health Clinics."
 - Current CHIP funding expires in 2015.
- Workforce policy
 - NHSC and THC Graduate Medical Education (THCGME) are currently funded with ACA funds; funding for both expires in 2015. The President's Budget would extend and expand NHSC and build upon THCGME.
 - NACHC is working with partners to extend funding.
- HRSA policy update
 - HRSA recently released PINs on Governance, Total Budget, and Sliding Fee Scale.
 - NACHC is keeping an eye on the 340B "Mega-Reg" that would provide increased oversight by Congress.
- Regulatory update: CMS
 - Medicare PPS Rule issued in May 2014 replaced the Medicare cap with a bundled payment rate. The transition will take place through 2015.

- Ongoing state-by-state Medicaid waivers and expansions.
- “Access Is the Answer” Campaign
 - High quality: Health centers already serve as the health care home to more than 22 million patients and are prepared to serve millions more
 - Cost effective: Health centers save the health care system billions of dollars
 - Local control: Health centers are locally owned and operated small businesses that create tens of thousands of jobs, leveraging a relatively small investment.
- NACHC Farmworker Health Committee
 - The Farmworker Health Network brought attention to the declining number of MSAWs patients and the implications of that trend for health centers.
 - Key factors: patients are not identified as MSAWs at intake; lack of health centers in rural areas; need for collaboration between growers and health centers.
 - The committee created a work group to make recommendations to reverse this trend (Innovation Strategies to Improve Access to Care) and set a goal to reach 1 million MSAW users.

Discussion

- Will funding continue for behavioral health integration?
 - The primary components for increased funding in the last year of the trust fund are oral health, behavioral health, vision care, and pharmacy services. The model is moving toward bundled payments and a focus on quality of care, with an integrated approach that addresses the whole person.
- Is Congress responsive to the information that NACHC provided regarding the importance of the health care safety net?
 - The health center program has broad support on both sides of the aisle. Education of new members of Congress who are elected in November will be critical. NACHC is asking health centers to assist in that effort.
- Importance of capturing MSAWs at intake
 - BPHC is working with NCHF to develop an intake form that will assist in identifying MSAWs.
- Is Medicare portable?
 - Medicare is a national program, but states determine how it is administered.

Council members identified the following issues to incorporate in recommendations to the Secretary:

- Emphasize the importance of behavioral health.
- Many issues depend upon collaboration among numerous organizations.
- Issues from the presentation on the aging MSAW workforce:
 - Need additional funding
 - Aging MSAWs require more specialty care
 - Need data differentiated by age and gender
 - Vision, oral health, and depression are prevalent concerns.

- Issues from the presentation on CHWs and behavioral health
 - CHWs have valuable information that can impact patient outcomes.
 - MSAWs present levels of complexity (language, culture, literacy, mobility).
 - Need continued funding for the CHW model.
 - Need data and outcome measures.
 - Health centers should partner with trained promotoras.

SUBCOMMITTEE MEETINGS AND REPORTS

The Council broke into subcommittees, as follows:

- Executive Committee (did not meet at this time): Jill Kilanowski (Chair), Edelmiro Garcia (Vice Chair), Jacqueline Rodrigue (DFO) (One vacancy)
- Migrant Health Services: Frances Canales (Chair), Edelmiro Garcia, Jesus Tijerina (Two vacancies)
- Access, Resources, and Financing: Wenceslao Vasquez (Chair), Jill Kilanowski, Martha Lopez, Rosa Martin, Jeffrey Partyka
- Public Policy and Advocacy: Gwendolyn Gould, Victoria Montoya, Joan Tronson (Two vacancies need to select a Chair)

The subcommittees identified the following issues for recommendations to the Secretary:

Migrant Health Services

- Specialty care for aging MSAW population
 - Dental, vision, geriatric, mental health, orthopedic
- ACA and Medicaid
 - Portability
- Discrimination
 - Insurance.

Public Policy and Advocacy

- Migrant health funds should be used to meet MSAW needs
- System of accountability
- ACA
 - Unique needs of MSAWs should be understood at the systems level
 - Multi-state plans or MSPs should be housed in CMS vs. OPM
- Funding to meet needs (e.g., extended hours)
- Holistic health
 - Align policies, approaches, etc. (vision, dental, behavioral health, pharmacy)
 - Changing demographics.

Access, Resources, Funding

- Cultural competence
 - Bilingual, culturally competent staff, including providers
 - Ethnically and racially diverse healthcare providers (role for NHSC)

- Enabling services accountability
- Need better definition
- Using NCFH tool to capture special populations
- Need better data.
- Funding
 - Continue funding for NHSC, outreach and enrollment
 - Interagency collaboration to disseminate information about multi-state enrollment, coverage for H-2A workers.
- Senior citizens
 - Specialty care
 - Behavioral health
 - Migrant voucher program as a model for specialty care.

LETTER OF RECOMMENDATIONS TO THE SECRETARY OF HHS

Council members identified key themes for the letter to the Secretary, with associated outcomes in each area:

- Holistic health across the lifespan
 - Vision, dental, behavioral health, pharmacy
 - Services for aging
 - Specialty care
 - Migrant voucher program is a potential model for specialty care
 - Outcome: Improved health status and quality of life, including existing clinical performance measures.
- Culturally appropriate accountable care
 - Bi-lingual staff (front desk and providers)
 - Better definition of cultural competency
 - Accountability for enabling services, including language competency
 - Use NCFH tool to capture special populations
 - Incorporate issues from MSAW testimonies
 - Outcomes: Increased utilization, efficient use of existing care, improved health status.
- Appropriate and adequate funding
 - Acknowledge and thank the Secretary for funding to support expanded services (vision/dental/behavioral health/pharmacy).
 - Continue FY15 funding for outreach and enrollment
 - Outcome: Increased enrollment, including H-2A workers.
 - Continue funding for NHSC
 - Outcome: More racially/ ethnically/linguistically diverse healthcare providers.
- Strategies for ACA enrollment
 - Incorporate recommendations proposed by Farmworker Justice.

- Interagency collaboration
 - Outcome: Better data on enrollees
- Need for portability
 - Outcome: Improved access to health care and improved health status.

REVIEW OF QUESTIONS FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

Council members discussed the MSAW testimonies and raised the following points:

- Some of the MSAWs who provided testimony at this meeting were related. That contributed to a strong emotional network, but it might have inhibited them from providing personal information.
- It is unrealistic to expect people to open up about personal issues with people they do not know. Questions about issues such as family violence should be indirect.
- The Council should provide clear guidance on the selection of participants for testimony sessions.
- Diversity of participants would be desirable, to the extent possible (e.g., unrelated, mix of genders and ages, different camps, different health centers).
- Questions should be designed to obtain the information the Council needs to make recommendations; they should not serve as a needs assessment for the local MHC.
- Avoid “yes/no” questions and invite MSAWs to tell stories about their experiences.
- Include questions about the social determinants of health (e.g., transportation, housing).
- Add a question about referral to a specialist.

Council members developed a revised list of questions for MSAW testimonies:

1. Please tell us about your personal experiences in receiving services at a migrant health center or community health center.
2. What is the biggest barrier to accessing health care?
3. Please tell us about a positive experience you had related to health care.
4. Please tell us about your experiences related to:
 - Housing
 - Transportation
 - Pesticides
 - Safety training.
5. Where would women in your community go for help if they experienced family violence?
6. Cultural competency
 - Please tell us whether health center staff and providers are able to speak your language.
 - Please tell us if health-related materials are available in your language.

7. Affordable Care Act
 - What information have you received about the Affordable Care Act (ACA)?
 - What barriers did you encounter if you tried to enroll?
8. What advice can you give us to improve conditions for you and other migrant agricultural workers around the country?

CLOSING – WRAP UP/SUMMARY

CDR Rodrigue expressed her appreciation for the Council and thanked members whose terms were expiring (Francis Canales, Gwendolyn Gould, Rosa Martin, Jesus Tijerina, Joan Tronson, and Wenceslao Vasquez).

Dr. Kilanowski noted that Mr. Garcia would make a presentation at the Midwest Migrant Stream Forum on behalf of the Council and asked Council members what the presentation should include. There was a general consensus that Mr. Garcia should provide an overview of the history and mission of the Council and should review the recommendations in the Council's most recent letter to the Secretary.

Council members proposed agenda items and speakers for the next meeting:

- BPHC update (CDR Rodrigue)
- Welcome from local primary care association and/or a local MHC
- Testimonies from teenage MSAWs
- Housing and environment (Tom Acury and Sara Quandt, Wake Forest University)
- Presentation by promotoras
- Family violence (Southwest Family Life Center)
- HIV and STDs (Thomas Painter, CDC)
- NACHC update (Joe Gallego)
- Update from Farmworker Justice
- Presentation by new cooperative agreement (National Center for Medical-Legal Partnership).

LOGISTICAL INFORMATION

Gladys Cate, Staff Support, NACMH

Ms. Cate reviewed the policy and procedures for reimbursement of travel expenses and urged Council members to submit their forms as soon as possible.

Dr. Kilanowski called for a motion to adjourn. The motion was made by Ms. Canales, seconded by Ms. Tronson, and carried by unanimous voice vote. The meeting was adjourned at 2:45 p.m.

TIMELINE FOR RECOMMENDATIONS LETTER		
Draft recommendations letter to Jill & Martha (copy to Gladys Cate & CDR Rodrigue)	Joan Tronson	October 31
Revised draft to Council members for review (copy to Gladys Cate & CDR Rodrigue)	Jill Kilanowski & Gladys Cate	November 5
Committee feedback to Jill (copy to Gladys & CDR Rodrigue)	All members	November 7
Final draft to Gladys & CDR Rodrigue	Jill Kilanowski	November 8
Approved draft to Chair and Vice Chair	Gladys Cate	TBD
Final letter submitted to the Secretary, with Chair and Vice Chair signatures	Jill Kilanowski	TBD

ADDITIONAL ACTION ITEM

- CDR Rodrigue will provide UDS data on dental and vision screenings.